



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NISAL CORP
PO BOX 24809
HOUSTON TX 77029

Respondent Name

INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative

Box Number 19

MFDR Tracking Number

M4-11-2728-01

MFDR Date Received

April 11, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TDI rule states that it is not enough for a carrier to file a TWCC denial code and that the carrier is required to submit claim specific language. Although the denial explanation is understandable it does not apply in this instance. Denial states: This bill is being reviewed in accordance with your Medrisk contract. Our facility does NOT have a contract with Medrisk, This [sic] statement by our facility has also been determined to be correct by the division. The denial code and their description are too vague for our facility to determine the basis for the denial. The denial is not in compliance with Rule 133.3."

Amount in Dispute: \$371.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request. A copy of the DWC060 request was placed in the insurance carrier representative box number April 12, 2011. The DWC060 was stamped received by Gordon Clayton with FOL Fileroom on April 14, 2011. As a result, a decision will be based on the documentation contained in the dispute at the time of the audit.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 1, 2010 and December 22, 2010	97032, 97110 x 2 and 97112 x 2	\$371.00	\$288.86

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 1 – This bill has been reviewed in accordance with your contract with MedRisk. All contracted Physical Therapy and-or Chiropractic charges should be billed through MedRisk at 2701 Renaissance Blvd., PO Box 61570, King of Prussia, PA, 19406.
- * – Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.
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Issues

1. Did the insurance carrier submit documentation to support the MedRisk contract denial?
2. Did the requestor bill in conflict with the NCCI edits?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason code "1 – This bill has been reviewed in accordance with your contract with MedRisk." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Consequently, the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code § 134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." The division completed NCCI edits to identify edit conflicts that would affect reimbursement. The following was identified:
The requestor billed for CPT codes 97032, 97110-GP and 97112-GP rendered on December 1, 2010. No NCCI edit conflicts were identified, as a result, the disputed CPT codes will be reviewed pursuant to 28 Texas Administrative Code § 134.203(c).
The requestor billed for CPT codes 97110-GP and 97112-GP rendered on December 22, 2010. No NCCI edit conflicts were identified, as a result, the disputed CPT codes will be reviewed pursuant to 28 Texas Administrative Code § 134.203(c).
3. Per 28 Texas Administrative Code § 134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."
Per 28 Texas Administrative Code § 134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title
Review of the submitted documentation finds that the requestor is entitled to reimbursement for the following:
Date of service December 1, 2010: The MAR amount for CPT code 97110-GP x 2 units \$86.77; CPT code 97112-GP \$45.00; and CPT code 97032 \$25.32, for a total recommended amount of \$157.09 for date of service December 1, 2010.
Date of service December 22, 2010: The MAR amount for CPT code 97110-GP x 2 units \$86.77; and CPT code 97112-GP \$45.00, for a total recommended amount of \$131.77 for date of service December 22, 2010.
The division finds that the requestor is entitled to a total reimbursement amount of \$288.86 for dates of service December 1, 2010 and December 22, 2010.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$288.86.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$288.86 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		January 16, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.